Department of Vermont Health Access

Request For Extension of Rehabilitation Therapy Services: ADULT OUTPATIENT

For the diagnoses of: stroke, traumatic brain injury, amputation, spinal cord injury, or severe burn.

Circle one: PT OT ST

Name _____ Dates/Events Complicating Therapy: Diagnoses and Dates Of Onset

Birthdate _____ _____ _____

Medicaid ID # _____ _____ _____

Provider Agency _____ _____ _____

Medicaid Provider # _____ Adherence to home program:_____ _____

Attending Provider (MD)Name_____ _____ _____

Attending Medicaid Provider (MD)#_____ _____ _____

Report Period	**Objective, measurable, patient oriented goals and research based treatment plan**	**Goals met/not met (circle one). If not met, provide current objective parameters**
First 30 combined Therapy visits Date of initial therapy for this calendar year: _____ Average time/treatment:_____ Procedure codes_____	Goal 1 _____ Goal 2 _____ Goal 3 _____ Treatment Plan inc. collaboration with other disciplines and community resource planning: _____ _____	Goal 1 met/not met _____ Goal 2 met/not met _____ Goal 3 met/not met _____ Date _____ Prof Signature _____
First request for treatment extension Date after 30 combined therapy visits: _____ Average time/treatment _____ # Visits requested:_____ Procedure codes_____ **Date:_____ MD Signature_____**	Goal 1 _____ Goal 2 _____ Goal 3 _____ Treatment Plan inc. collaboration with other disciplines and community resource planning: _____ _____	Goal 1 met/not met _____ Goal 2 met/not met _____ Goal 3 met/not met _____ Date _____Prof Signature_____
Second request for treatment extension Average time/treatment:_____ # Visits requested:_____ Procedure codes_____ **Date:_____ MD Signature_____**	Goal 1 _____ Goal 2 _____ Goal 3 _____ Treatment Plan (include procedure codes): _____ _____	Goal 1 met/not met _____ Goal 2 met/not met _____ Goal 3 met/not met _____ Date _____Prof Signature_____

REQUESTS FOR EXTENSION OF REHABILITATION THERAPY SERVICES: ADULT OUTPATIENT

After 1/1/11, outpatient physical, occupational and speech therapy services are covered for 30 combined visits upon initial physician certification. A written request by the practitioner to extend the period of treatment beyond the 30 combined visits for the diagnoses of: stroke, traumatic brain injury, spinal cord injury, amputation, and severe burn must be submitted to the Department of VT Health Access at least 14 days prior to the end of the 30 combined visits or subsequent authorization periods to avoid interruption of payment. **The request must include:**

- Beneficiary name, date of birth and Medicaid unique ID
- Provider name and VT Medicaid provider number
- Name of attending physician and VT Medicaid provider number
- Date of initial therapy for the condition
- Date and events complicating therapy that affect extension of Medicaid service, including hospitalizations
- Documentation re: adherence to home program
- Primary and other relevant diagnosis with dates of onset
- Final dates of the 30 combined visit period
- Number of treatments and average time per treatment during the initial 30 combined visit period
- Objective, measurable goals for the initial 30 visit period
- Research based treatments/ procedures provided during the initial 30 visit period. Include interdisciplinary collaboration and community resource planning. A discharge plan should be put in place at the time of the initial evaluation
- Whether each goal was met or not met
  If goals were not met, current objective parameters
- Number of therapy visits being requested
- Average time per treatment during upcoming authorization period
- Objective, measurable goals for the upcoming authorization period
- Research based treatments/ procedures to be provided during the upcoming authorization period
- Date & Therapists Signature with professional designation
- **Date & Signature of Physician**

This information can be provided by use of the extension form on the reverse side or by another form which contains all of the above information. A Medicare 700/701 form or HCFA 485-7 may be utilized, provided that any of the required information listed above that is missing from the form is added to it before it is sent to DVHA. Any additional attachments which further clarify the beneficiary's medical status and treatment are welcome.

INSTRUCTIONS FOR USE OF THE DVHA MEDICAID EXTENSION FORM FOR ADULT OUTPATIENT THERAPY SERVICES

FIRST SUBMISSION OF THIS FORM:
FILL OUT **COMPLETELY** 14 DAYS BEFORE INITIAL 30 COMBINED VISIT PERIOD IS OVER:

- Top area of form with basic information
- Box 1, column 1 with information from the first 30 visits of treatment
- Box 1, column 2 with goals and plan from the first 30 visits of treatment
- Box 1, column 3 for current goal status
- Box 2, column 1 with information for the upcoming authorization period
- Box 2, column 2 with goals and plan for the upcoming authorization period

SECOND SUBMISSION OF THIS FORM:
FILL OUT **COMPLETELY** 14 DAYS BEFORE THE SECOND AUTHORIZATION PERIOD:

- Box 2, column 3 for current status and results of treatment
- Box 3, column 1 with information for the upcoming authorization period
- Box 3, column 2 with goals and plan for the upcoming authorization period

ADDITIONAL SUBMISSIONS:
Continue to fill out the form using the above format. Note that this form is on a word document and so the response area expands as the form is completed electronically.

Please save a copy of this form for your records. The Medicaid copy can be sent to the DVHA at 312 Hurricane Lane, Suite 201, Williston, VT 05495 or faxed to (802) 879-5963. Please call (802) 879-6396 for clinical questions regarding therapy, including in servicing, documentation and coverage. For PA status and billing issues please call HP Provider Services at 1-800-925-1706 or (802) 878-7871.